CONCEPTUAL DESIGN OF MODEL AUTOMATED EPSDT CASE MANAGEMENT SYSTEM (REVISED)

MACRO
macro systems inc.

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Prepared for

Health Care Financing Administration

Macro Systems, Inc.
Silver Spring, MD

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I. INTRODUCTION

I. INTRODUCTION

In May 1979, Macro Systems, Inc., prepared a conceptual design for a model automated EPSDT case management system for the State of California. In September 1979, the Health Care Financing Administration contracted with Macro to update the conceptual design based on several factors. These included:

- Changes in Federal penalty regulations and national reporting requirements
- Review of the model system against the operations of two county CHDP programs
- Further review of State systems that could interface with the model system, including the Medi-Cal Eligibility Data System (MEDS), the Child Health Information Claiming Unit (CHIC) System, the Denti-Cal Claims Processing System, and the Medi-Cal Claims Processing System.

The model system presented herein is designed primarily to be a county-operated system, supported by various State systems. In recent weeks, HCFA and the State have decided to develop a statewide automated EPSDT case management system. The State system would be supplemented by individual county systems in meeting State and county case management needs. For those counties that are too small to justify automation, the State system will serve as the primary case management support vehicle. For other counties, the State system would perform certain key case management functions in lieu of or as backup to county systems. Although the model system is basically designed to be county operated, nearly all of its features are easily adaptable to a State system. Further, although the model system is designed as an automated system, many of its forms, procedures, and data flows are also useful for counties operating manual case management systems.

The following sections of this chapter describe the purpose of the model automated EPSDT case management system in more detail, the activities performed in developing the conceptual design, and the organization and contents of the report.

1. PURPOSE OF THE MODEL EPSDT CASE MANAGEMENT SYSTEM

This report presents a conceptual design for a model EPSDT case management system for the State of California. Because of the wide diversity in county CHDP/EPSDT program size, organization, staff, and data processing capabilities, the model system does not prescribe forms, procedures, hardware, software, or reports for counties to use in performing case management functions. Rather, the model system identifies the requirements that must be met by a case management system; the types of forms, reports, procedures, and system configurations that could be used to meet these requirements; and key issues that need to be resolved by State and county programs to implement effective case management systems.

A major objective of the model case management system is to assist the State and county programs in meeting Federal penalty regulations and reporting requirements for case management. As such, the model system contains the basic features needed to respond to these requirements as well as other components useful in effective case management. Other features can be added by county CHDP programs to provide more sophisticated tracking or reporting capabilities or to accommodate the unique characteristics of county operations. In addition, the model system is modular in design, so a county can implement selected features and perform various functions in either an automated or manual fashion.

Other purposes of the model system include:

- Enhance uniformity in county case management systems and procedures to ensure that regulations and reporting requirements are met
- Provide a model in which counties can adapt selected features and, thus, reduce system development costs

- Provide guidelines for the development of the State-level case management system

- Define the necessary county inputs for the State-level system

2. ACTIVITIES PERFORMED IN DEVELOPING THE MODEL SYSTEM CONCEPTUAL DESIGN

The conceptual design was developed based upon extensive review and analysis of State and county CHDP/EPSDT program operations. Specifically, the following activities were conducted:

- Conducted detailed reviews of EPSDT systems and procedures in eight California counties. These counties included:

  - Los Angeles
  - Santa Clara
  - Yolo
  - Orange
  - Kern
  - San Bernardino
  - Sonoma
  - San Francisco

- Conducted review of State CHDP/EPSDT operations; this included meetings with the State CHDP Program branch chiefs, section heads, and field technical assistance staff, as well as personnel from the Medi-Cal procurement project, the MEDS development project, the Bureau of Data Services, and the Department of Social Services

- Reviewed the Medi-Cal Claims Processing System, the Medi-Cal Eligibility Data System, the CHIC System, and the Denti-Cal Claims Processing System to determine potential uses of these systems in supporting case management activities

- Reviewed the HCFA-developed General Systems Design (GSD) to determine applicable features for use in California

- Met with State EDP Subcommittee for case management

- Conducted extensive review of Federal penalty regulations, CHAP legislation, and Federal reporting requirements

- Reviewed case management systems currently in use and proposed for other States

As will be seen in the succeeding chapters, the California model system is considerably less complex than the GSD and is tailored to the characteristics of the California program. In addition, maximum effort has been placed on using existing systems, such as the State Medi-Cal claims processing system, in meeting case management needs. As was noted earlier, certain changes may need to be made in these systems to support case management effectively. Because of this, the model system presents alternative approaches for use by the counties until such changes can be made.

3. ORGANIZATION AND CONTENTS OF THIS REPORT

The report is organized into several chapters in addition to Chapter I, Introduction.

Chapter II: System Requirements--Presents the requirements imposed on county case management systems by Federal EPSDT penalty regulations and reporting requirements and identifies the functions the model case management system must perform.

Chapter III: System Operations--Describes major features and detailed operations of the model case management system.

Chapter IV: System Outputs--Describes the input forms and output reports that would be produced by the model case management system.

Chapter V: System Interfaces--Discusses potential interfaces of the model system with other State and county systems.

Chapter VI: Implementation Issues--Discusses certain issues that need to be resolved and steps that should be taken to support the further development of the model system.

Appendix: Data Items--Describes the individual data elements that are included in the model system. Definitions of key terms are included.

II. SYSTEM REQUIREMENTS

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This chapter describes the requirements imposed on State and county case management functions by the Federal penalty regulations and proposed national reporting requirements. The requirements listed reflect written and oral interpretations issued by HCFA staff.

1. EPSDT FEDERAL PENALTY REGULATIONS (42 CFR 441)

Federal penalty regulations related to case management are presented for the following:

- Activities that must be performed
- Documentation that must be maintained on activities

Exhibit I, following this page, describes the regulations.

2. EPSDT FEDERAL REPORTING REQUIREMENTS (PROPOSED)

Federal EPSDT reporting requirements are presented for the Quarterly Child Health Status Report. Exhibit II, following Exhibit I, lists these requirements.

3. STATE AND COUNTY CASE MANAGEMENT FUNCTIONS

Case management, as required for the EPSDT program, refers to the activities that need to be performed by the State or county agency to ensure that a client:

- Is identified as being eligible for the program
- Is informed about the program

EXHIBIT I(1)
Health Care Financing Administration

FEDERAL EPSDT PENALTY REGULATIONS

ACTIVITIES WHICH MUST BE PERFORMED

1. Inform newly eligible families within 60 days from eligibility determination.

2. Reinform non-participating families at least annually.

3. Screen and initiate treatment (for all referable conditions discovered during the screen) within 120 days from date of service request or from date periodic screen is due in 75% of cases, or within 180 days from service request or periodic screen due date in 95% of cases.

   The State is exempt from this requirement if it can demonstrate, with supportive evidence, that within the designated time periods, either:

   . The family lost eligibility

   . The State was not able to locate the family or child despite a good faith effort to do so

   . The child's failure to receive necessary services was due to an action or decision by the family, rather than a failure by the State to meet the regulatory requirements, e.g.

     - The State offers and the family declines support services (scheduling and transportation assistance)

     - The family declines further participation in the EPSDT program. A declination is a negative response or an undecided response to a verbal offer; or a negative response or no response to a written offer

4. Refer eligible EPSDT participants over age 3 to a dentist for dental screening and treatment, according to the State's dental periodicity schedule. Dental treatment is considered initiated when the child gets to the dentist's office for the encounter. The State is exempt from this requirement if it can demonstrate, with appropriate documentation, that:

   . The family declined the dental screen, and the date of the declination

   . The child has already received a dental screen within the periodicity time frame for the child's age, and the date of the dental screen

5. Offer and provide support services (scheduling assistance and transportation) as requested by the client (for the initial screen, required follow-up treatment and the periodic screen)

6. Provide screening services according to the State's periodicity schedule for all EPSDT participants, e.g., all individuals who have received an EPSDT screen. For penalty liability purposes, the 120/180 day requirements apply to the rescreening due date, defined as the earlier of the following dates:

   . The date of the State's offer of support services to have the child rescreened

   . The last day of the month in which the child's age exceeds the oldest allowable age for that rescreening in the periodicity schedule

7. Provide partial screening services for families who choose to receive EPSDT services from a provider that does not furnish the full range of EPSDT services. The agency must provide for the non-furnished EPSDT services within 120 days (75% of cases), or 180 days (95% of cases), from the date of the client's request for the services from the State that are not offered by the provider.

8. Provide referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnoisis. This referral assistance must include giving the family the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.

DOCUMENTATION WHICH MUST BE MAINTAINED

State must have available:

1. Monthly lists or a sample of lists (as specified by HEW) containing for that month:

   . Newly approved AFDC cases

   . AFDC cases where no member of an eligible family participates in the EPSDT program

   . Names and case numbers of AFDC recipients requesting screening, and the dates of those requests

   . Names and case numbers of AFDC recipients due for rescreening under the State's periodicity schedule

2. For cases comprising the sample drawn in (1) above:

   . Names of families informed of the availability of EPSDT services within 60 days of eligibility determination or annually, and the date they were informed

   . Names of AFDC families or recipients who decline initial or periodic EPSDT services and the date of that declination

   . Names of AFDC families or recipients who choose to receive services from a provider who does not provide the full range of EPSDT services, the date on which they request services that are not covered by the provider, and the dates that these requested services are provided

   . Names of AFDC families or recipients who were offered and declined support services (transportation and scheduling assistance) and the dates of offer and declination

   . Names of AFDC families or recipients who requested support services, and the dates on which the agency provided this assistance

   . Names of AFDC families or recipients requesting medical and/or dental screening but State has documentation that appropriate services were previously provided (and the dates) in accordance with the State's periodicity schedule

3. For each recipient screened by a provider who provides the full range of EPSDT services: (irrespective of whether or not support services were requested/provided)

   . Name and case number of the recipient

   . Dates of each screening

   . Screening services provided and each screening finding, including findings on conditions needing follow-up treatment

   . Dates on which follow-up treatment was initiated for those conditions requiring treatment

   . Names of each recipient who required treatment for conditions not covered by the plan and the efforts to refer them to providers willing to treat them at little or no expense to the family

PENALTY LIABILITY

The State will have 1% of its Federal reimbursement for AFDC withheld unless it:

1. Performs the initial informing within 60 days from eligibility determination in at least 95% of the cases

2. Performs the annual informing every 12 months for EPSDT non-participants in at least 95% of the cases

3. Provides screening and treatment initiation when necessary within 120 days (75% of cases) or 180 days (95% of cases) after the initial request for screening or the date rescreening was due under the periodicity schedule. State is not liable for meeting timeliness requirements if family declines support services

4. Meets the documentation requirements specified in 45 CFR 441.90

CHILD HEALTH QUARTERLY STATUS REPORT (PROPOSED)

(Prepared At End Of Quarter)

Form Item No.	Data Element
	SECTION I - POPULATION CHARACTERISTICS
1.	Number of individuals under 21 eligible for Medicaid this quarter (newly approved and already on rolls)
2.	Number of individuals under 21 eligible for Medicaid who requested EPSDT service during the quarter (does not include "walk-ins")
3.	Number of individuals under 21 participating in EPSDT who were due this quarter for assessment or reassessment according to periodicity schedule (includes all who were due under the State's periodicity schedule for reassessment)
4.	Number of individuals under 21 participating in EPSDT this quarter due for intitial dental referral (requested dental at intake and/or due for dental referral based on periodicity schedule
	SECTION II - SERVICE TO ELIGIBILE POPULATION THIS QUARTER
1.	Number of individuals under 21 with completed assessments excluding dental
2.	Number of individuals under 21 with problems identified during assessment excluding dental
3.	Number of individuals under 21 whose treatment was initiated for (all) problems discovered as a result of assessments, excluding dental
4.	Number of individuals under 21 referred to a dentist for diagnosis and treatment who are being seen as an initial referral and/or for reassessment according to a periodicity schedule (includes those who received either an initial or periodic dental screen)
5.	Number of individuals under 21 found to have incomplete immunizations
6.	Number of individuals under 21 who had been incompletely immunized who became completely immunized for age and health history
7.	Number of individuals under 21 who received services comparable to EPSDT in organized settings (for example, PHP's , ICF's, Migrant Health Clinics, etc.).

CHILD HEALTH QUARTERLY STATUS REPORT (continued)

Form Item No.	Data Element
8.	Number of Preventive Health Encounters for individuals under 21, defined by codes

SECTION III - NUMBER OF PROBLEMS FOR WHICH TREATMENT WAS INITIATED THIS QUARTER (by problem)

SECTION IV - EXPENDITURE INFORMATION (dollar expenditures for diagnosis and treatment, excluding dental)

- Is offered and receives necessary assistance in scheduling and keeping screening and treatment appointments
- Receives required screening services
- Receives required diagnosis and treatment services

In essence, case management consists of those activities needed to track a client effectively through the program to ensure that appropriate and required screening and treatment services are offered, delivered, and documented in a timely and efficient manner.

(1) County Case Management Functions

In California, as in most States, EPSDT services are provided by the counties. Thus, case management is largely a county responsibility. Expanding on the items described above, county case management functions include the following:

- Establishing eligibility for EPSDT services
- Informing the client about the availability of EPSDT services (i.e., medical, dental, and support services)
- Providing detailed information about the program, including services offered, benefits, available service providers, etc.)
- Periodic informing and scheduling of services for clients already in the program (i.e., clients who have received at least one screen), according to a predefined State periodicity schedule
- Scheduling screening appointments for clients
- Offering and arranging transportation or other ancillary services to assist a client in keeping a screening appointment
- Following up to ensure that screening appointments were kept and to determine the outcome of the screens
- Offering and arranging transportation or other ancillary services to assist a client in keeping a treatment appointment
- Following up to ensure that diagnosis and treatment were provided for each problem identified during screening

- Identification and contact with qualified providers and referring clients to such providers

- Performing management reporting and evaluation to ensure that the above functions are carried out in a timely and efficient manner, that problem areas are identified, that corrective actions are taken, and that Federal and State reporting requirements are met

- Documenting services provided to support program management and Federal penalty regulations

(2) State Case Management Functions

The State CHDP Program funds and administers the program, provides direction and technical assistance to county CHDP/EPSDT programs, monitors and evaluates county programs, and pays claims for covered screening services.* In addition, the State processes and accumulates data to supplement county systems in meeting Federal penalty regulations and reporting requirements. This function, limited at present, will be expanded once interfaces of county EPSDT systems with State systems, such as the Medi-Cal Eligibility Data System (MEDS) and the Medi-Cal Claims Processing System, are developed. Once these interfaces are established, the State will operate a case management system at the State level to serve as a backup to county systems and to provide case management support to those counties without sufficient resources to develop their own systems. The State will also assume the periodic informing function for all children two years of age or over; i.e., notices and reports will be produced by the State instead of the counties. The State will also continue to pay screening and treatment claims and process the various statistical information on the claim forms (PM 160 and Medi-Cal billing form) to support the Federal reporting requirements. In addition, because claim forms for Denti-Cal are not returned to the counties, the State system will be the only mechanism to support automated tracking of dental screens.

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* Claims for diagnosis and treatment services are handled by the State Medi-Cal Claims Processing System.

As part of its overall supervisory responsibilities, the State's case management functions will also include:

- Monitoring county programs to identify problem areas and technical assistance needs (e.g., to determine whether counties are complying with timing requirements for delivery of screening and treatment services)

- Performing research on particular aspects of county operations such as number and types of conditions found, number of screens conducted by different types of providers, number of clients accepting offers of services, etc.

The model automated EPSDT case management system has been designed to meet the above requirements. The next chapter describes the features and operation of the model system.

III. SYSTEM FEATURES AND OPERATION

III. SYSTEM FEATURES AND OPERATION

This chapter describes the major features and operation of the model EPSDT automated case management system.

1. OVERVIEW OF MODEL SYSTEM

As discussed earlier, the model system has been designed to assist the State and county agencies in meeting Federal penalty regulations and reporting requirements for case management as well as State and county program management needs. Recognizing the available resources and wide diversity in county programs, the model system has been designed around the following guidelines:

- Be modular so that counties can implement selected components of the model system, for example, informing or screening assistance, while continuing to perform other functions manually.
- Be as simple in concept as possible to ensure that the system can be operated efficiently by county CHDP/EPSDT workers.
- Use, to the maximum extent practical, existing State and county systems to avoid duplication and reduce costs. Thus, counties may wish to use the periodicity system being developed at the State level to support this function.
- Be flexible in enabling the State and counties to extract key information from the database to support program management needs.
- Provide exception reporting to reduce the amount of paper that a county must process and review, and, at the same time, identify critical actions that need to be taken to meet Federal penalty regulations, for example, to identify clients who have not received screening and treatment services in a given time period.
- Accommodate the special characteristics of the California program. Several other State and county case management systems were studied in detail. However, the model system was designed only after both the current organization and operational environments

of the State and county programs were studied and matched against the applicable Federal regulations and reporting requirements. The model system is, therefore, a conservative approach toward meeting the Federal requirements with a minimum of disruption of current county systems and practices.

In meeting the above objectives, the model system identifies five major functional areas that will necessarily be a part of all county programs. These functions are: (1) Intake/Informing, (2) Screening Assistance, (3) Tracking Delivery of Key Services, (4) Periodicity, and (5) Management Reporting. These are then subdivided into component activities and a logical set of forms and reports that support the activities.

The model system utilizes an existing form (the PM 160) as well as two new forms--the CHDP referral form and the client tracking form. The client tracking form is intended to be the primary form for recording relevant events as a client progresses from initial informing through screening and treatment initiation. For automated systems, this form will be computer-generated after Intake/Informing and will be updated by the EPSDT worker and submitted for data processing as required to inform the system of the client's status. The system will process the form and produce a new, updated tracking form to enable the EPSDT worker to verify its correctness and perform further client tracking. Thus, the client tracking form will serve as a "turnaround document." In all cases, the worker will retain a copy of the tracking form in the client's folder before sending it to data processing.

As the system receives information on the client through submission of the tracking form, as well as the PM 160, it will produce a series of reports. These reports are intended to assist the county in identifying and managing its case load at various stages in the client flow, in identifying actions that need follow-up, in meeting Federal documentation and reporting requirements, and in monitoring and evaluating its operations.

2. BASIC SYSTEM MODULES

As indicated above, the model system has been designed around five basic modules. These are:

- Intake/Informing Module--This module establishes the case/client database for the system. All families (and individual clients) initially informed about EPSDT at the time of AFDC or Medi-Cal eligibility determination are entered into the system. Referrals for screening assistance are made. A basic client tracking form used for recording subsequent services given to clients is produced by the system. A report of the clients requesting CHDP services is produced.

- Screening Assistance Module--This module provides for documenting the offer of scheduling and transportation services to assist a client in receiving a screen, the client's reponse to the offer of these support services, and date of provision of the assistance. This information is recorded on the client tracking form. As an option, this module also generates appointment reminder notices for those appointments arranged by the CHDP worker.

- Tracking Module--This module provides for follow-up of screening and diagnosis and treatment to ensure that required services are provided within the mandated time frame and that the necessary documentation on delivery of services is recorded. This module includes two major subsystems: Screening Follow-Up and Diagnosis and Treatment Follow-Up. To support tracking, reports are produced indicating clients who have not been screened and/or treated within specified time periods.

- Periodicity Module--This module informs the family and county agency of the need for periodic rescreening of clients. It also generates notices of rescreening for mailing to the families.

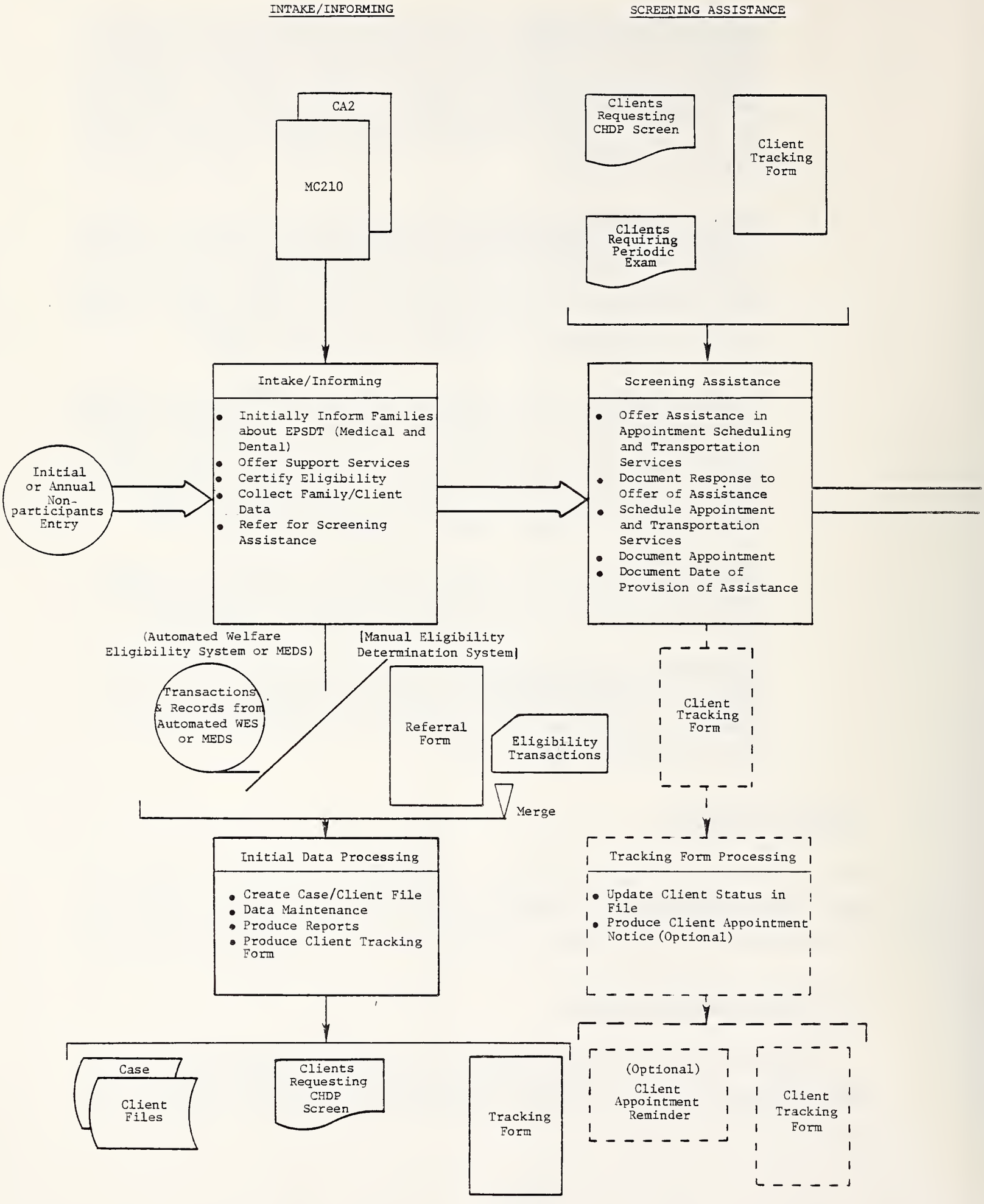
- Management Reporting Module--This module provides for accumulation of data and generation of reports to assist a county in meeting (1) Federal penalty regulations for documentation, (2) Federal reporting requirements, and (3) county and State program management requirements.

3. SYSTEM OPERATION

The overall operation of the system is described in Exhibit III, following this page. The exhibit describes the relationship of the five major system modules. The operation of each module is described in the paragraphs that follow.

(1) Intake/Informing Module

A client enters the EPSDT system at the time of AFDC/Medi-Cal eligibility determination. At this time, the applicant completes the appropriate


INTAKE/INFORMING
SCREENING ASSISTANCE
CA2
MC210
Clients Requesting CHDP Screen
Client Tracking Form
Clients Requiring Periodic Exam
Intake/Informing
• Initially Inform Families about EPSDT (Medical and Dental)
• Offer Support Services
• Certify Eligibility
• Collect Family/Client Data
• Refer for Screening Assistance
Screening Assistance
• Offer Assistance in Appointment Scheduling and Transportation Services
• Document Response to Offer of Assistance
• Schedule Appointment and Transportation Services
• Document Appointment
• Document Date of Provision of Assistance
Initial or Annual Non-participants Entry
(Automated Welfare Eligibility System or MEDS)
[Manual Eligibility Determination System]
Transactions & Records from Automated WES or MEDS
Referral Form
Eligibility Transactions
Client Tracking Form
Merge
Initial Data Processing
• Create Case/Client File
• Data Maintenance
• Produce Reports
• Produce Client Tracking Form
Tracking Form Processing
• Update Client Status in File
• Produce Client Appointment Notice (Optional)
Case
Client Files
Clients Requesting CHDP Screen
Tracking Form
(Optional)
Client Appointment Reminder
Client Tracking Form

SCREEN FOLLOW UP

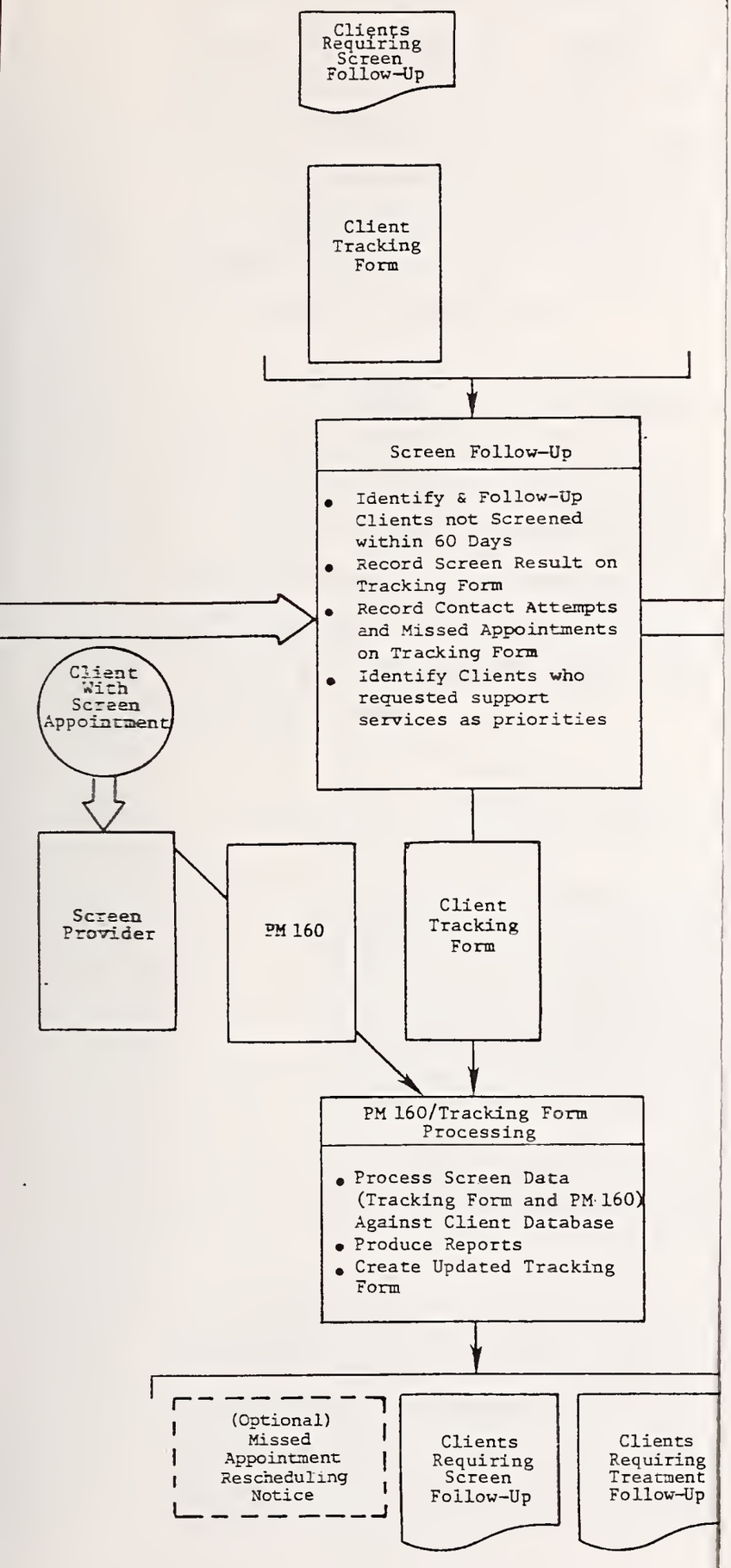


EXHIBIT III

Health Care Financing Administration

OVERALL SYSTEM OPERATION

MANAGEMENT REPORTING

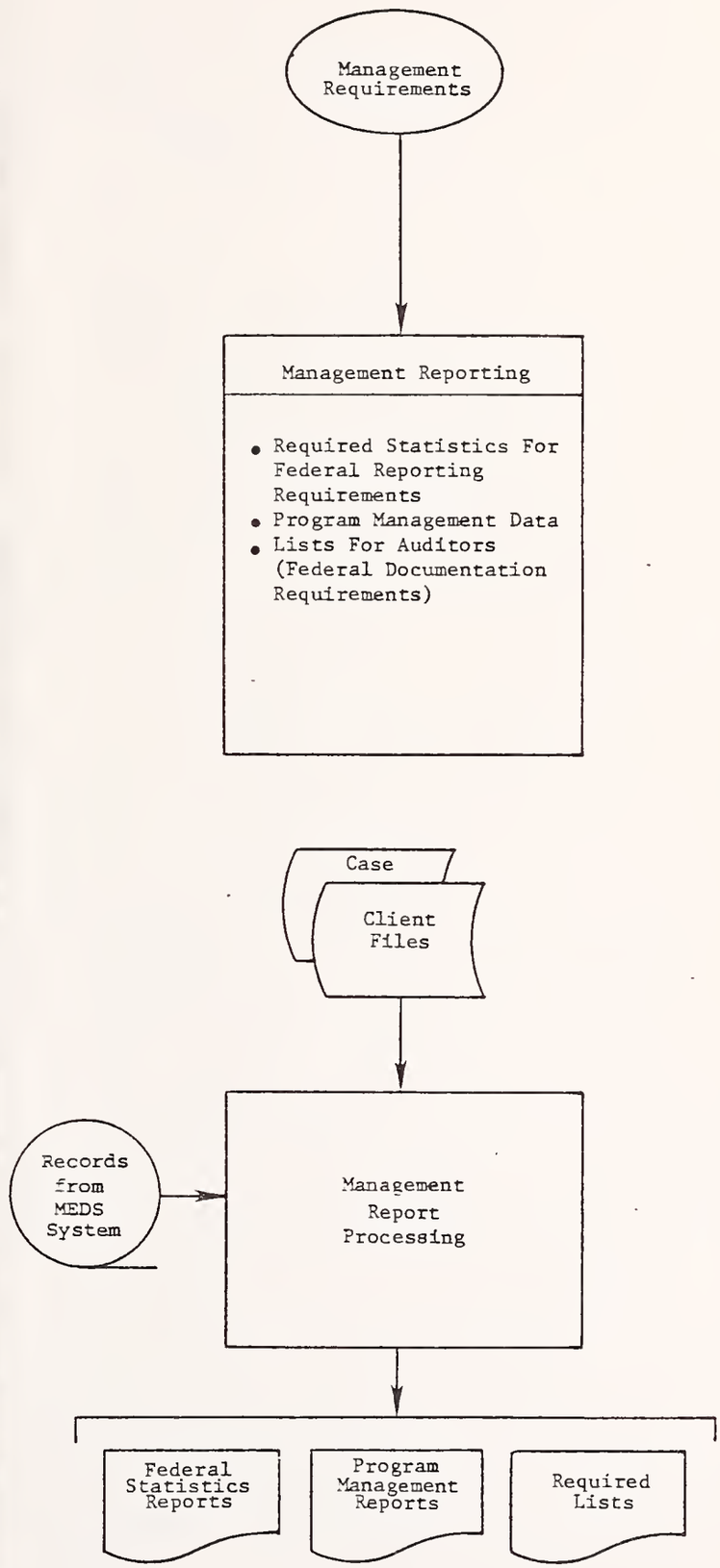


EXHIBIT III

Health Care Financing Administration

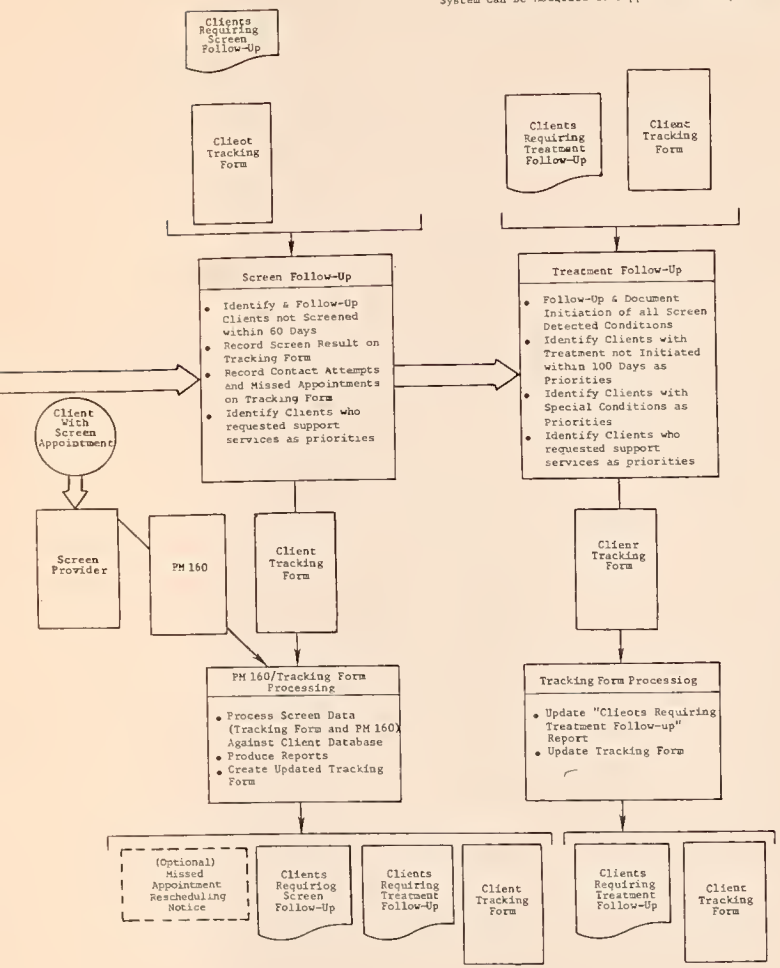
OVERALL SYSTEM OPERATION

TRACKING

SCREEN FOLLOW UP

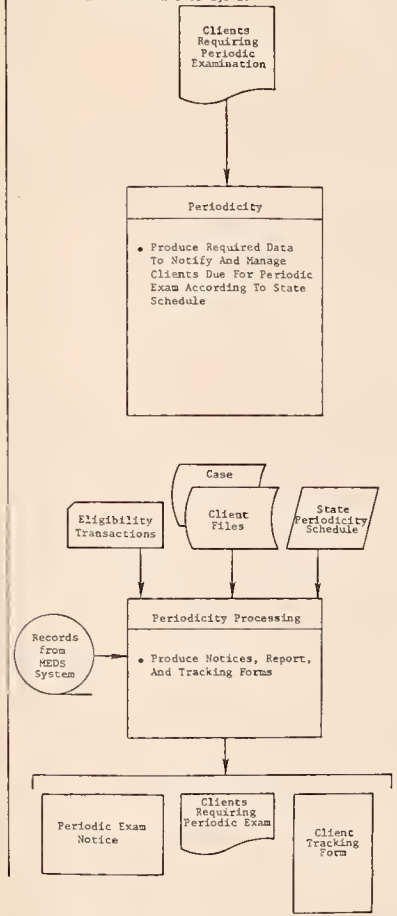
DIAGNOSIS AND TREATMENT FOLLOW-UP *

*Process To Be Used Until Medi-Cal Claims Processing System Can Be Modified To Support EPSDT Requirements

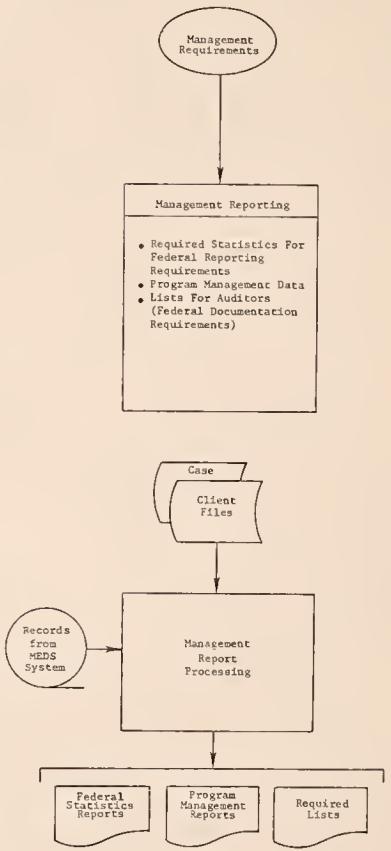


PERIODICITY **

** Will probably be assumed by State for children age 2 and older. County module required for children under age 2; option for children over age 2.



MANAGEMENT REPORTING



section of the CA2 or MC210 forms indicating his/her acceptance or rejection of EPSDT services (medical, dental, and support services) or desire for further information about the program. The eligibility worker completes a CHDP Referral Form, indicating basic information about the family and the client and the family's decision on the use of EPSDT services. The referral form is submitted to EPSDT data processing to establish the EPSDT case/client file. Exhibit IV, following this page, presents a copy of a sample Referral Form.

If a county has an automated eligibility system, the Referral Form may not be required. In such cases, the appropriate eligibility forms would have to be modified (as they already have been in some counties) to record the necessary EPSDT decision information, and the EPSDT case/client file would be created automatically from the county's automated eligibility system. Once the necessary interfaces between EPSDT and the MEDS system are established, MEDS could then be used to create the EPSDT case/client file.

The EPSDT case/client file is then used to produce two basic outputs:

- To support screening assistance, a report, "Clients Requesting a CHDP Service," is produced biweekly. All clients who have indicated they want EPSDT services (medical or dental) are listed on this report. To enable a county to prioritize its activities, the report is subdivided by those clients requesting and not requesting support services. The 120/180 day timing regulations apply only for clients who have requested support services. A county may, however, wish to track all clients.

- To support subsequent tracking and documentation of services, a client tracking form is produced. Exhibit V, following Exhibit IV, presents this form.

In the earlier version of the Conceptual Design, reports indicating all clients who were informed about EPSDT and their service decisions were produced by the model system. As indicated in Chapter II, the Federal penalty regulations no longer require a hard-copy report with this information--only that the State or county be able to provide this information

EXHIBIT IV

Health Care Financing Administration

CHDP REFERRAL FORM

County of

Case Name:	Case Medi-Cal Number:	Eligibility Det. Date

Case Address:	Telephone:

	CHDP Eligible Client Name	Sex (M/F)	Medi-Cal Number	Birth Date
1				
2				
3				
4				
5				
6				
7				

Informing Type	Medical Services:	Dental Services:	Support Services:
_____ Initial _____ Annual Informing Date	Decision ☐ Date	Decision ☐ Date	Decision ☐ Date

Decision Codes: 1 - Services Accepted; 2 - Services Rejected; 3 - Undecided

Eligibility Worker Name	Worker ID No.	Phone Number

Notes:

CHDP CLIENT TRACKING FORM

County of

Case/Client ID

Case Name:

Case Medi-Cal Number:

Services Requested:
- ☐ Medical
- ☐ Dental
- ☐ Support

Client Name:

Client Medi-Cal Number:

Client Sex

Client Birth Date

Client Address:

Telephone Number:

Service Request Date:

Screen Type
- ☐ Initial
- ☐ Periodic

Screening Assistance

Contact Attempts

	Type	Date	Cont. Made?
1			
2			

Declines Services
- ☐ Medical
- ☐ Dental

Screen Deferral Date

Medical Screen Provider Type

Support Services

Type Req.	Dates Provided
	Ⓢ
	Ⓣ
	Ⓣ

Screening Appointments

Medical		Dental	
Provider		Provider	
Address		Address	
	Date / Time		Date / Time
1		1	
2		2	

Worker Name:

ID No.

Phone / Date

Screen Follow-Up

Contact Attempts

	Type	Date	Cont. Made?
1			
2			

Screen Appointment

Status / Date

Medical

Dental

Screen Results

Worker Name:

ID No.

Phone / Date

Treatment Follow-Up

Contact Attempts

	Type	Date	Cont. Made?
1			
2			

Referrable Conditions:

Code	Tx Start Date	Code	Tx Start Date
Code	Tx Start Date	Code	Tx Start Date
Code	Tx Start Date	Code	Tx Start Date

Support Services

Type Req.	Dates Provided
	Ⓢ
	Ⓣ
	Ⓣ

Worker Name:

ID No.:

Phone:

Date:

Special Conditions:

Final Disposition

Final Disposition

Disposition Date

Data Processing Use:

Ⓢ Scheduling

Ⓣ Transportation

TREATMENT APPOINTMENTS

Code	Provider Name	Provider Address	Appointment Date/Time
☐			
☐			
☐			
☐			
☐			
☐			
☐			
☐			

COMMENTS/NOTES:

on demand, for example, from county case records. Accordingly, reports containing this information have been deleted.

(2) Screening Assistance Module

Using the report of "Clients Requesting a CHDP Service" and the client tracking form, the CHDP worker provides screening assistance. The CHDP worker records on the client tracking form applicable information about the client, for example:

- Offer and client acceptance of assistance for appointment scheduling and transportation services to assist a client in receiving screening
- Date of provision of the above support services
- Date of screening appointment and name of screening provider, if arranged by CHDP worker
- Client's acceptance or rejection of EPSDT services
- Attempts to contact a client, including the type, date, and result of the attempt

The client tracking form is retained by the CHDP worker in the client's folder for subsequent use in tracking. As clients receive screening assistance, they should be crossed off the "Clients Requesting a CHDP Service" report so that the CHDP supervisor and workers can monitor their work load and schedule screening assistance activities.

Option For Screening Assistance Module

As an option, to support more intensive follow-up of screening appointments, the county could elect to have the client tracking form processed by the computer after screening assistance. In this option, two additional outputs would be produced:

- A new, updated client tracking form, with the results of the screening assistance process printed on the form by the computer
- An appointment reminder notice for mailing to clients whose appointments are scheduled by the CHDP worker

(3) Tracking Module

As indicated earlier, the Tracking Module includes both screening follow-up (tracking to the screen) and diagnosis and treatment follow-up.

Screening Follow-Up Subsystem

The proposed Federal penalty regulations require a client to receive a screen and, if conditions are found, to have diagnosis and/or treatment initiated for each condition within 120 days from the date of request for services.* Thus, to meet the 120-day clock, both screening and treatment must be performed in a timely fashion. Because of the frequently long time period required to establish eligibility, contact clients, schedule appointments, and receive screening claim reports, counties must track clients to ensure that services are delivered in the required time frame. Tracking is a time-consuming and expensive process; therefore, some way to prioritize clients is needed.

Many counties currently perform tracking through the use of various types of tickler systems. Although such systems can be very effective, for counties with a large eligible population or with inexperienced CHDP staff, this can be an inefficient and inaccurate process. Therefore, to support this activity, the report of "Clients Without Medical Screen 60 Days from Request" is produced by the system. This report lists those clients for whom no medical screen has been provided within 60 days of request for services. Sixty days has been chosen as an intermediate point

* As described in Chapter II, the penalty applies only to those clients who request support services.

in the 120-day cycle at which a key activity (i.e., screening) should be performed in order to comply with the requirement that screening be completed and treatment be initiated within 120 days of request for services. Thus, this report can be considered an exception report or a "hot list" of clients needing immediate screen follow-up. This report would be produced biweekly.

Because the timing requirements apply only to those clients who request support services, counties may elect to track only these clients, or at least to prioritize their tracking efforts accordingly. To support this process, the report is subdivided into those clients requesting and not requesting support services.

A client will remain on this report until one of two things happens: (1) a PM 160 is received by the county indicating that a screen has occurred or (2) the CHDP worker, in the follow-up process, learns that the screen was performed, that the client missed the appointment, or that the client decided to decline the screening services.

In the first instance, the PM 160 would automatically update the case/client file in the computer and remove the client from the "Clients Without Medical Screen 60 Days from Request" report.

In the second instance (where the CHDP worker learned of the screen before the PM 160 was received), the CHDP worker would complete the client tracking form, indicating the following:

- Whether the screening appointment was kept
- Date of screen
- Whether referable conditions were identified
- Whether treatment was initiated at the time of the screen for all conditions found

The client tracking form would then be sent to the computer for processing. Those clients who had (1) received a screen, (2) missed an

appointment, or (3) voluntarily dropped out of the program would be removed from the "Clients Without Medical Screen 60 Days from Request" report. In addition, a new client tracking form with the latest client information printed by the computer would be produced for subsequent tracking.

As noted on the client tracking form, space is provided to record contact attempts in performing the screening follow-up functions. Such information would not be entered into the computer system but is included to document situations in which no record existed of a screen and the county had made a good faith effort to contact the client to determine if a screen had occurred. In the event of an audit, such documentation would be required.

Tracking Dental Screens

The procedure described above for tracking the provision of a medical screen cannot be used for dental services. Counties currently do not receive copies of the Denti-Cal claim form--the equivalent of the PM 160, which indicates that a dental screen has been provided. It is also unlikely that the counties will receive copies of the Denti-Cal forms in the future. As such, county CHDP programs must rely on telephone follow-ups to determine if a dental screen has occurred. Should a county elect this option, the model system could produce an exception report, "Clients without Dental Screen 60 Days from Request." This report would, of course, be driven and updated only by the notation on the tracking form that the dental screen had occurred. The report would be produced biweekly and be subdivided by clients requesting and not requesting support services.

To avoid the paperwork associated with submitting the tracking forms once a dental screen has occurred, a county may elect not to include this report in the model system. Such a report could be produced in the future by the State, once the MEDS system is developed and interfaces with the State CHDP and Denti-Cal systems are developed.

In the interim, the counties may wish to rely on tickler systems or other manual methods to perform the dental tracking function.

Diagnosis And Treatment Follow-Up Subsystem

In addition to updating the Screening follow-up report, the receipt of a PM 160 or a client tracking form will generate a report, "Clients Without Treatment Initiation." This report will list clients with conditions identified during the screen that require diagnosis and treatment. If the conditions are treated at the time of the screen, these clients will not appear on this report. This report will also be produced biweekly.

The most efficient way to perform treatment follow-up and meet treatment documentation and reporting requirements is through the Medi-Cal claims processing system. However, this requires that certain interfaces of the Medi-Cal system and the EPSDT system be established, specifically:

- EPSDT-related treatment services should, ideally, be identified on the Medi-Cal claim form.
- Problem codes on the PM 160 should correspond to the treatment codes on the Medi-Cal form, or some type of cross-walk mechanism must be established.
- Medi-Cal claim forms must be submitted in a timely fashion by providers, and the information must be transmitted in a timely fashion to the counties.
- The MEDS system must be implemented because MEDS is the only vehicle at the State level for recording the date of request for services.

A more detailed discussion of the use of the Medi-Cal claims processing system in supporting the EPSDT model system is presented in Chapter V. Until (and if) the necessary interfaces are developed, the CHDP worker must track and record the provision of treatment manually. Whereas the 120-day timing requirements apply only to those clients who request support services, the penalty documentation requirements mandate that treatment initiation for all referable conditions be documented for all clients,

regardless of whether they request support services. Thus, the treatment follow-up function is extremely important.

When the PM 160 is received by the county, applicable conditions will be coded on the tracking form by the CHDP worker. Using the tracking form and the report, "Clients Without Treatment Initiation," he/she will follow up clients in need of treatment. This will probably have to be done by calling the client or provider--a somewhat cumbersome process but, until the interfaces with the Medi-Cal claims processing system are developed, a necessity.

The CHDP worker can prioritize the treatment follow-up activity by examining the status of clients on the treatment follow-up report. The report will distinguish two main categories of clients requiring treatment follow-up:

- Priority I Clients--Clients for whom treatment has not been initiated for all referable conditions within 90 days of request for services. These clients must be followed up immediately to meet the 120-day requirement.

- Priority II Clients--Clients for whom treatment has not been initiated for all conditions but for whom more than 30 days remain on the clocks. Such clients require treatment follow-up, but the timing problem is not as great as for the Priority I clients.

The report is subdivided by the above two categories. Further, each of the two categories is subdivided by clients requesting and not requesting support services because this identifies the clients subject to the 120-day penalty regulations.

In addition, the report identifies those clients for whom a particularly serious problem was determined during the screen. This information can serve to remind CHDP workers of the need to exercise special follow-up activities to ensure that the client receives treatment as rapidly as possible.

In sum, all clients who have referable conditions for which treatment has not been initiated will appear on this report. The comprehensiveness of the report, constituting more than just an exception report, is necessary in order to meet the Federal penalty documentation requirements, as discussed earlier.

As the CHDP worker performs treatment follow-up, he/she will make the necessary entries on the client tracking form. The treatment initiation dates for each referable condition will be recorded on the tracking form. When treatment is initiated for all conditions, the tracking form should be sent to CHDP data processing. Clients appearing on the "Clients Without Treatment Initiation" report will be eliminated from the report at that point.

Similar to screening, CHDP workers in many counties schedule treatment appointments for their clients. Space is provided on the reverse side of the client tracking form to note treatment appointments as well as other comments the CHDP workers may wish to record.

(4) Periodicity Module (Optional)

Clients who have received CHDP services in the past will be scheduled for subsequent screens according to the State's predefined periodicity schedule. The periodicity schedule will be input into the computer. A report, "Clients Due for Periodic Examination," will be produced on a monthly basis.

Clients will appear on this report the month preceding the date they are due for a rescreen, according to the periodicity schedule. Clients will appear on the report only once. This report will meet the penalty documentation requirements and also provide the county with a case load listing of clients due for periodic examination.

In addition, an appointment notice will be generated for mailing to the client at the time listed above. In accordance with the penalty regulations, the appointment notice will include an offer of support services. Further, a client tracking form will be produced by the computer at this time.

Clients who enter the system through periodicity will be tracked similarly to clients entering at AFDC/Medi-Cal eligibility determination. Such clients will, thus, appear in screening and treatment follow-up reports until screening and treatment initiation are concluded.

The State CHDP Program plans to develop an automated periodicity system to provide the capabilities described above. Reports and notices would be produced by the State system and sent to the appropriate counties and parents. The State currently plans to limit the system to children two years of age or older. This module of the model system should, therefore, be considered optional for county development. Counties will still, of course, be responsible for performing the periodicity function for children under the age of two.

The State automated periodicity system will also provide for issuing notices for periodic dental examinations. These will occur one year from the date of the last dental screen.

(5) Management Reporting Module

This module will produce a series of reports needed to comply with Federal reporting and documentation requirements as well as to support State and county program management needs. Required data will be extracted from the model system case/client database as well as databases maintained at the State level. As an example, the following reports can be produced:

- Screening Activity--A report describing the number of screens conducted, by type of screen (initial and periodic) and client age.
- Problems Identified During Screen--A report indicating the number of conditions found during screens, by condition and client age.
- Treatment Initiation--A report indicating the number of conditions for which treatment was initiated, by condition and client age.

- Program Management Statistics--A report presenting key statistics about the county program, for example:

  - Percent of clients informed who request CHDP medical services
  - Percent of clients informed who request CHDP dental services
  - Percent of clients informed who request support services
  - Average days elapsed from request for services to screen or request for services to initiation of treatment
  - Percent of clients initiating treatment within (N) days from request for services

It should be pointed out that the reports on screening activity and problems identified during a screen could be generated by the State as well as the county because the necessary data are captured on the PM 160. The Treatment Initiation Report could also be produced by the State, when the interfaces with the Medi-Cal Claims Processing System are established. Further, the above reports are only illustrations of the types of management reports that could be produced by the model system. The case/client database can permit varying arrays of data to support State and county program management needs.

* * * *

This chapter has described the various modules, forms, reports, and data flows of the model case management system. A more detailed description of the system outputs is presented in the next chapter.

IV. SYSTEM OUTPUTS

IV. SYSTEM OUTPUTS

This chapter describes in further detail the various sample input forms and output reports of the system. Exhibit VI, following this page, presents a summary of each report, indicating the purpose, frequency, and user of the report. Following the summary, layouts of each form and report are presented.

As noted on Exhibit VI, several of the reports are intended to be produced by the State only and, as such, would not be part of the model system. Examples are the report of newly approved AFDC cases and the report of preventive health encounters. Other reports, such as Report 9B, "Problems Identified During Screen," could be produced at either the State or county level but more appropriately at the State level. These reports have been included for completeness--to describe the set of reports required to meet the penalty documentation and quarterly reporting requirements.

EXHIBIT VI

Health Care Financing Administration

EPSDT MODEL SYSTEM OUTPUTS

REPORT	PURPOSE	FREQUENCY	USER
1 Newly Approved AFDC Cases	Meet Regulation Documentation requirements. Prepared by State System.	Monthly or upon demand	Federal and State Officials
2. AFDC Cases Not Participants in CHDP	Meet Regulation Documentation requirements. Produced by State System.	Monthly or upon demand	Federal and State Officials
3. Clients Requesting CHDP Service	Meet Regulation Documentation requirements. Provide CHDP Unit with case-load listing. Assist in scheduling screening assistance services and determining work load.	Bi-weekly	Federal and State Officials; County CHDP unit
4. Clients Without Medical Screen 60 Days After Request	Alert CHDP Unit of clients who have not received a medical screen within 60 days of request for service and therefore require follow-up to meet timing penalty regulations.	Bi-weekly	CHDP Unit
5. Clients Without Dental Screen 60 Days After Request	Alert CHDP Unit of clients who have not received a dental screen within 60 days of request for services and require screen follow-up to meet penalty regulations. Produced by State System.*	Bi-weekly	CHDP Unit
6. Clients Without Treatment Initiation	Alert CHDP Unit of clients who have had referrable conditions identified during a screen and for whom treatment has not been initiated for all conditions. Support 120/180 day timing and documentation regulations and Federal reporting requirements.	Bi-weekly	CHDP Unit
7. Clients Due For Periodic Examination	Notify CHDP Unit that client is due for periodic screen. Ensure that periodic screens are offered and provided in timely fashion. Support Regulation Documentation requirements. Produced by State System.	Bi-weekly	Federal and State Officials; CHDP Unit
8. Client Referral Form (Manual Eligibility Systems)	Create EPSDT case/client database. Refer to Screening Assistance.	As informing is performed	County Welfare Dept CHDP Unit
9. Client Tracking Form	Enable CHDP workers to report client progress from Screening Assistance through treatment initiation for all conditions. Enter data into computer for update of case/client database and generation of reports	As services occur	CHDP Unit
10. Preventive Health Encounters	Support Federal reporting requirements to provide numbers of Medicaid eligible individuals under age 21 who receive treatment from physicians on their own initiative. Produced by State System.	Quarterly	Federal and State Officials
11. Management Reports	Support Federal reporting requirements, documentation requirements and State/County program management needs.	Quarterly	Federal and State Officials, County CHDP Program Managers
12. Notice of Periodic Examination	Notify clients participating in CHDP that, according to the periodicity schedule, their next screen is due.	When periodic exam is due	Client
13. Notice of Screening Appointment (Optional)	Remind client of screening appointment.	After screen is scheduled	Client

* As Denti-Cal forms are not returned to counties, this report can only be produced at the State level.

REPORT LAYOUT

REPORT NAME: NEWLY-APPROVED AFDC CASES

PROGRAM: 1

NEWLY-APPROVED AFDC CASES

COUNTY - XXXXXXXXXXX

CASE NAME	CASE NUMBER	DATE OF ELIGIBILITY DETERMINATION
XXXXXXXXXXXXXXX	99999999999999	MM/DD/YY

COUNTY - XXXXXXXXXXXXX

CASE NAME	CASE NUMBER	DATE OF ELIGIBILITY DETERMINATION
XXXXXXXXXXXXXXX	99999999999999	MM/DD/YY

REPORT LAYOUT

REPORT NAME: AFDC CASES NOT PARTICIPATING IN CHDP

PROGRAM: 2

AFDC CASES NOT PARTICIPATING IN CHDP

COUNTY - XXXXXXXXXXXX

RUN DATE - MM/DD/YY

CASE NAME	CASE NUMBER	DATE OF ELIGIBILITY DETERMINATION
XXXXXXXXXXXXXXXXXXXX	9999999999999	MM/DD/YY

REPORT LAYOUT

REPORT NAME: CLIENTS REQUESTING CHDP SERVICES

PROGRAM: 5

COUNTY XXXXXXXXXXXXX

PAGE 9999
DATE MM/DD/YY

CASE NAME	CLIENT NAME	CLIENT MEDI-CAL NUMBER	CLIENT ADDRESS	CLIENT TELEPHONE NUMBER	DATE OF REQUEST	DAYS FROM REQUEST	SERVICES REQUESTED MEDICAL	SERVICES REQUESTED DENTAL
XXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX	999999999 9999	9999 XXXXXXXXXX	999-999-9999	MM/DD/YY	999	*	*

PART A -- CLIENTS WHO REQUESTED SUPPORT SERVICES

PART B - CLIENTS WHO DID NOT REQUEST SUPPORT SERVICES

REPORT LAYOUT

REPORT NAME: CLIENTS WITHOUT MEDICAL SCREEN 60 DAYS FROM REQUEST

PROGRAM: 4

CLIENTS WITHOUT MEDICAL SCREEN 60 DAYS FROM REQUEST

COUNTY XXXXXXXXXXXXX

PAGE 9999
DATE MM/DD/YY

CASE NAME	CLIENT NAME	CLIENT MEDI-CAL NUMBER	CLIENT ADDRESS	CLIENT TELEPHONE NUMBER	DAYS FROM REQUEST
XXXXXXXXXX	XXXXXXXXXXXX	9999999999999	9999 XXXXXXXXXX	999-999-9999	999

PART A = CLIENTS WHO REQUESTED SUPPORT SERVICES

PART B = CLIENTS WHO DID NOT REQUEST SUPPORT SERVICES

REPORT LAYOUT

REPORT NAME: CLIENTS WITHOUT DENTAL SCREEN 60 DAYS FROM REQUEST

PROGRAM: 5

CLIENTS WITHOUT DENTAL SCREEN 60 DAYS FROM REQUEST

COUNTY XXXXXXXXXX

PAGE 9999
DATE MM/DD/YY

CASE NAME	CLIENT NAME	CLIENT MEDI-CAL NUMBER	CLIENT ADDRESS	CLIENT TELEPHONE NUMBER	DAYS FROM REQUEST
XXXXXXXXXXXXXXX	XXXXXXXXXXXXXX	9999999999999	9999XXXXXXXX	999-999-9999	999

PART A : CLIENTS WHO REQUESTED SUPPORT SERVICES

PART B : CLIENTS WHO DID NOT REQUEST SUPPORT SERVICES

REPORT LAYOUT

REPORT NAME: CLIENTS WITHOUT TREATMENT INITIATION

PROGRAM: 6

CLIENTS WITHOUT TREATMENT INITIATION

COUNTY XXXXXXXXXXX

PAGE 9999
DATE MM/DD/YY

PART I - TREATMENT NOT INITIATED FOR ALL CONDITIONS WITHIN 10 DAYS FROM REQUEST

CASE NAME	CLIENT NAME	CLIENT MEDI-CAL NUMBER	DAYS FROM REQUEST	SPECIAL CONDITIONS
XXXXXXXXXXXX	XXXXXXXXXXXX	99999999999999	999	*

PART A - CLIENTS WHO REQUESTED SUPPORT SERVICES

PART B - CLIENTS WHO DID NOT REQUEST SUPPORT SERVICES

PART II TREATMENT NOT INITIATED FOR ALL CONDITIONS

PART A - CLIENTS WHO REQUESTED SUPPORT SERVICES

PART B - CLIENTS WHO DID NOT REQUEST SUPPORT SERVICES

REPORT LAYOUT

REPORT NAME: CLIENTS DUE FOR PERIODIC EXAMINATION

PROGRAM: 7

CLIENTS DUE FOR PERIODIC EXAMINATION

COUNTY XXXXXXXXXXXXXX

PAGE 9999
DATE MM/DD/YY

CASE NAME	CLIENT NAME	CLIENT MEDI-CAL NUMBER	CLIENT ADDRESS	CLIENT TELEPHONE NUMBER	CLIENT BIRTH DATE	DATE OF LAST SCREEN	FIRST SCREEN DUE DATE	LAST SCREEN DUE DATE	SCREEN DUE MEDICAL	SCREEN DUE DENTAL
XXXXXXXXXXXXXX	XXXXXXXXXX	9999999999A	9999XX XXXXXX	999-999-9999	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	*	*

CHDP REFERRAL FORM

County of

Case Name:	Case Medi-Cal Number:	Eligibility Det. Date

Case Address:	Telephone:

	CHDP Eligible Client Name	Sex (M/F)	Medi-Cal Number	Birth Date
1				
2				
3				
4				
5				
6				
7				

Informing Type	Medical Services:	Dental Services:	Support Services:
_____ Initial _____ Annual Informing Date _____	Decision ☐ Date _____	Decision ☐ Date _____	Decision ☐ Date _____

Decision Codes: 1 - Services Accepted; 2 - Services Rejected; 3 - Undecided

Eligibility Worker Name	Worker ID No.	Phone Number

Notes:

CHDP CLIENT TRACKING FORM

County of

Case/Client ID

Case Name:

Case Medi-Cal Number:

Services Requested:
- ☐ Medical
- ☐ Dental
- ☐ Support

Client Name:

Client Medi-Cal Number:

Client Sex

Client Birth Date

Client Address:

Telephone Number:

Service Request Date:

Screen Type
☐ Initial ☐ Periodic

Screening Assistance

Contact Attempts

	Type	Date	Cont. Made?
1			
2			

Declines Services
- ☐ Medical
- ☐ Dental

Screen Deferral Date

Medical Screen Provider Type

Support Services

Type Req.	Dates Provided
	Ⓢ
	Ⓣ
	Ⓣ

Screening Appointments

Medical			Dental		
Provider			Provider		
Address			Address		
	Date	Time		Date	Time
1			1		
2			2		

Worker Name:

ID No.

Phone | Date

Screen Follow-Up

Contact Attempts

	Type	Date	Cont. Made?
1			
2			

Screen Appointment

Status	Date
Medical	
Dental	

Screen Results

Worker Name:

ID No.

Phone | Date

Treatment Follow-Up

Contact Attempts

	Type	Date	Cont. Made?
1			
2			

Referrable Conditions:

Code	Tx Start Date	Code	Tx Start Date

Support Services

Type Req.	Dates Provided
	Ⓢ
	Ⓣ
	Ⓣ

Worker Name:

ID No.:

Phone:

Date:

Special Conditions:

Final Disposition

Final Disposition

Disposition Date

Data Processing Use:

Ⓢ Scheduling

Ⓣ Transportation

TREATMENT APPOINTMENTS

Code	Provider Name	Provider Address	Appointment Date/Time
☐			
☐			
☐			
☐			
☐			
☐			
☐			

COMMENTS/NOTES:

CHDP CLIENT TRACKING FORM CODE SHEET

I. CASE/CLIENT I.D.- Produced by computer. Services requested (medical, dental support) at Intake will be indicated by 1 for service requested, 2 for service declined

II. SCREENING ASSISTANCE

1. Contact Attempts - Screening Assistance

Type:

1 Home Visit
2 Office Visit
3 Telephone Call
4 Letter

Date - Enter date of each attempt

Contact Made - Enter results of contact attempt - Y = Yes, N = No

2. Declines Service

Enter (X) if client declines either medical or dental screen

3. Medical Screen Provider Type

1. Screening Only provider
2. Comprehensive Care provider
3. Prepaid Health Plan
4. Other

4. Screen Deferral Date

If client rejects screen at this time, and wishes it to be postponed to a later date (for example, to coincide with school or sports physicals) enter the date on which the client would like to be screened.

5. Support Services

Type Requested:

1. No support services requested
2. Scheduling only requested
3. Transportation only requested
4. Scheduling and transportation requested

Dates Provided

Enter dates on which support services were provided. Enter at (S) line for scheduling support. Two (T) lines are provided to document two separate dates for transportation assistance. Additional documentation of support services should be entered under "Comments/Notes."

6. Screening Appointments

Space is provided to record medical and dental appointments scheduled for client by CHDP worker. For those counties who select the option, an appointment reminder notice will be produced.

III. SCREEN FOLLOW-UP

1. Contract Attempts

Type:

1 Home Visit
2 Office Visit
3 Telephone Call
4 Letter

Date - Enter date of each attempt

Contact made - Enter results of contact attempt - Y = Yes, N = No

2. Screen Appointment

Status:

Enter client's action for medical and dental screens:

1 Kept appointment
2 Missed appointment

3. Screen Results - Enter results of screen visit

1 No problems

2 Problems identified, treatment initiated for all conditions during screen visit

3 Problems identified, no treatment initiated for any condition during screen visit

4 Problems identified, treatment initiated for one or more conditions; other conditions remaining

5 Problems identified, client declined treatment

6 Problems identified, treatment contraindicated

4. Omitted Procedures

Enter PM160 code of any procedures omitted during the screen

01 History and Physical Exam
02 Dental Assessment
03 Nutritional Assessment
04 Snellen or MCT
05 Audiometric
06 Hemoglobin or Hermatocrit
07 Urine Dipstick
08 TB: Tine or PPD

IV. TREATMENT FOLLOW-UP

1. Contact Attempts

Type:

1 Home Visit
2 Office Visit
3 Telephone Call
4 Letter

Date - Enter date of each attempt

Contact made - Enter results of contact attempts - Y = Yes, N = No

2. Referrable Conditions

Code

Enter three-digit code to indicate screen procedure: First two-digits are problem suspected, third digit is screener's follow-up code.

First two digits:

01 History and Physical Exam
02 Dental Assessment
03 Nutritional Assessment
04 Snellen or MCT
05 Audiometric
06 Hemoglobin or Hematocrit
07 Urine Dipstick
08 TB: Tine or PPD
13 Sickle Cell: Electrophoresus
14 Lead: FEP
15 Lead: Blood Lead
16 VDRL, RPR or ART
17 G.C. Culture
18 Pap Smear
19 PKU: Blood
20 Urinalysis

Third digit

1. No follow up necessary
2. Screening procedure recheck scheduled
3. Dx and Rx initiated this visit
4. Examiner to follow up for Dx/Rx
5. Referred for Dx/Rx
6. Referral refused
7. Unknown

3. Tx Start Date

Enter the date that treatment was initiated

4. Special Conditions

Enter "x" to denote condition discovered during screen which is considered particularly serious or chronic for special attention during treatment follow-up.

V. COMMENTS/FINAL DISPOSITION

1. Comments/Notes

Space is provided for worker to enter comments or notes

2. Final Disposition

1 Client declines further services

2 Client cannot be contacted

3 Client moved

4 Client lost Medi-Cal eligibility

5 Client declines further program participation

6 All actions completed

3. Disposition Date

Enter date on which case disposition was made.

REPORT LAYOUT

REPORT NAME: QUARTERLY SCREENING AND TREATMENT STATISTICS

PROGRAM: 9 A

QUARTERLY SCREENING AND TREATMENT STATISTICS

PART A -- SCREENING ACTIVITY

RUN DATE - MM/DD/YY
QUARTER - MON-MON
YEAR - 9999

99999 -- NUMBER OF INDIVIDUALS FOUND TO HAVE INCOMPLETE IMMUNIZATIONS
99999 -- NUMBER OF INDIVIDUALS COMPLETING IMMUNIZATIONS

99999 -- NUMBER OF INDIVIDUALS WITH TREATMENT INITIATED THIS QUARTER FOR ALL PROBLEMS DISCOVERED AS A RESULT OF ASSESSMENT

SCREEN STATISTICS BY AGE FOR THIS QUARTER

	<1	1-5	6-12	13-17	18+	TOTAL
TOTAL SCREENS (COMPLETE)						
INITIAL SCREENS						
PERIODIC SCREENS						
FEMALES						
MALES						

REPORT LAYOUT

REPORT NAME: QUARTERLY SCREENING AND TREATMENT STATISTICS

PROGRAM: 9B

PART B -- PROBLEMS IDENTIFIED DURING SCREEN

COUNTY - XXXXXXXXXXXXXXX

PAGE-9999
DATE-MM/DD/YY

	TOTAL	4-5	6-12	13-17	18-20
HISTORY AND PHYSICAL					
DENTAL ASSESSMENT					
NUTRITIONAL ASSESSMENT					
SNELLEN OR MCT					
AUDIOMETRIC					
HEMOGLOBIN OR HEMATOCRIT					
URINE DIPSTICK					
TB: TINE OR PPD					
SICKLE CELL					
LEAD: FEP					
LEAD: BLOOD LEAD					
VDRL, RPR OR ART					
GC CULTURE					
PAP SMEAR					
PKU: BLOOD					
URINALYSIS					

REPORT LAYOUT

REPORT NAME: QUARTERLY SCREENING AND TREATMENT STATISTICS

PROGRAM: 9C

PART C - TREATMENT INITIATION

COUNTY - XXXXXXXXXXXXXXXXXX

PAGE - 9999
DATE - MM/DD/YY
QUARTER - MON-MON

NUMBER OF PROBLEMS FOR WHICH TREATMENT WAS INITIATED

	TOTAL	<1	1-5	6-12	13-17	18-20
VISION	XX	XX	XX	XX	XX	XX
HEARING	XX	XX	XX	XX	XX	XX
PHYSICAL GROWTH/EMOTIONAL DEVELOPMENT/LEARNING	XX	XX	XX	XX	XX	XX
NUTRITIONAL	XX	XX	XX	XX	XX	XX
CARDIOVASCULAR/CIRCULATORY/PULMONARY/RESPIRATORY	XX	XX	XX	XX	XX	XX
GENITAL/URINARY TRACT	XX	XX	XX	XX	XX	XX
HEMATOLOGIC	XX	XX	XX	XX	XX	XX
DIABETES	XX	XX	XX	XX	XX	XX
TUBERCULOSIS	XX	XX	XX	XX	XX	XX
LEAD TOXICITY	XX	XX	XX	XX	XX	XX
ALL OTHERS	XX	XX	XX	XX	XX	XX
UNKNOWN	XX	XX	XX	XX	XX	XX

REPORT LAYOUT

REPORT NAME: Quarterly Screening and Treatment Statistics

PROGRAM: 9D

PROGRAM MANAGEMENT STATISTICS

Run Date: MMDDYY
Quarter: MON1 - MON2
Year: 9999

Activities:

999999 Number of cases informed
99% Percent requesting medical screen
99% Percent requesting dental screen
99% Percent requesting support services
99% Percent of screens completed with conditions

Timing:

999 - Average days elapsed from request for screen to screen
999 - Average days elapsed from request for screen to treatment initiation for all referrable conditions

- Percent of clients initiating treatment within (N) days of screen date

99% ≤ N days
99% ≤ 100 days
99% ≤ 180 days
99% > 180 days

REPORT LAYOUT

REPORT NAME: PREVENTIVE HEALTH ENCOUNTERS

PROGRAM: 10

PREVENTIVE HEALTH ENCOUNTERS

COUNTY XXXXXXXXXXX

PAGE 9999
DATE MM/DD/YY

CASE NAME	CLIENT NAME	CLIENT MEDICAL NUMBER	ENCOUNTER DATE	CPT/RVS CODE
XXXXXXXXXXXXX	XXXXXXXXXXXXX	999999999	MM/DD/YY	99999999

TOTAL NUMBER OF CLIENTS THIS PAGE 99999

TOTAL NUMBER OF CLIENTS CUMULATIVE 999999999

V. SYSTEM INTERFACES

V. SYSTEM INTERFACES

The model EPSDT automated case management system is intended to make maximum use of existing systems at the State and county levels in meeting case management needs. This is necessary to reduce duplication and State and county system development costs. Accordingly, interfaces will be established between the model system and the following State and county systems:

- Automated county welfare eligibility systems
- State Medi-Cal Eligibility Data System (MEDS)
- State CHDP Claims Processing System (PM 160)
- State Denti-Cal System
- State Medi-Cal Claims Processing System
- Existing county CHDP/EPSDT systems
- State-level EPSDT system

1. AUTOMATED COUNTY WELFARE ELIGIBILITY SYSTEMS

There are three principal systems in use--Case Data, Honeywell, and WISMUS. Counties with such systems, may not be required to complete a special referral form to establish the EPSDT case/client database. In such cases, the EPSDT case/client file may be created as an automated spin-off from the eligibility system. However, certain data entry forms used in these systems may need to be modified to include information on the EPSDT service decision (medical, dental, and support services) and decision date. Such an interface will reduce the clerical effort of the eligibility worker in completing a special CHDP referral form.

An additional interface with the model system is to use automated eligibility systems to update an EPSDT client's eligibility status and address. This will reduce the effort required to process eligibility transactions manually to update the EPSDT case/client database.

2. STATE MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

This system, currently being implemented in four test counties, will provide for on-line connections between the State and county welfare departments to support daily updating of the Medi-Cal eligibility file and on-line inquiry by the counties. The system will enable changes in eligibility status and client address to be processed more rapidly and, thus, improve the currentness of the database. The system will provide a unique identifier for each client so that clients moving from one county to another can be readily identified as existing eligibles. In addition, the system will reduce the time to produce Medi-Cal cards, thereby reducing the time between informing and screening assistance. This will enhance a county's ability to comply with the penalty timing requirements, as many programs do not contact a client for screening assistance until eligibility has been established and a Medi-Cal card issued.

MEDS, when fully implemented in the State (scheduled for 1982), will enable the State to operate a State-level case management system if the appropriate information on services offered, client decisions, and the date of eligibility determination are included in the MEDS database. The date of eligibility determination is, for practical purposes, the service request date, which starts the penalty clock. Current MEDS specifications do not include all the required EPSDT information. Once this information is available, MEDS could then enable the State to track the delivery of screening services against the penalty timing requirement by matching the receipt of the PM 160 against the EPSDT case/client database created by MEDS.

In addition, MEDS could be used to support tracking of the delivery of treatment services if the necessary interfaces of the CHDP Claims Processing (PM 160) and the Medi-Cal Claims Processing System are established. Also, the MEDS system could be used in off-processing hours to transmit tracking reports to the counties through the terminals located in each county welfare office. The timeliness of this process to meet county tracking requirements is, however, questionable.

3. STATE CHDP CLAIMS PROCESSING SYSTEM (PM 160)

The CHDP claim form--the PM 160--can serve to alert a county that a screen has occurred and that treatment is required (or has been initiated) for certain referable conditions. When merged with the county EPSDT case/client file, the receipt of the PM 160 will:

- Update the report on "Clients Without a Medical Screen 60 Days from Date of Request"
- Generate the report, "Clients without Treatment Initiation"
- Identify specific referable conditions that require diagnosis and treatment (for use in follow-up)

As indicated earlier, the CHDP client tracking form, if received before the PM 160, will perform the above functions, although the PM 160 is needed regardless to identify and record specific referable conditions requiring diagnosis and treatment follow-up.

The PM 160 forms will also enable the State and counties to meet specific Federal documentation and reporting requirements, for example,

- Number of initial and periodic screens by client age
- Number of problems identified during the screen, by client age and problem
- Number of clients with incomplete immunization
- Number of clients with incomplete immunization who were immunized during the period

The above information could be generated either by the counties or the State because the required data would reside in both the model system and the State CHDP Claims Processing System (assuming that the counties receive a copy of the PM 160).

In addition, merging the PM 160 and MEDS databases will enable generation of screening tracking reports at the State level. The PM 160 database will also enable the State to perform the periodicity notification function at the State level. Further, interfaces of the PM 160, MEDS, and Medi-Cal Claims Processing System databases will support the development of treatment tracking reports at the State level.

The State CHDP Program has, in recent months, instituted a new PM 160 form. Also, the level of automation of the claims processing function has been increased, which should enhance the use of the PM 160 for reporting purposes.

4. DENTI-CAL SYSTEM

The Denti-Cal Claims Processing System is totally separate from the CHDP and Medi-Cal Claims Processing Systems. The operation of the Denti-Cal system is currently being recompeted. As Denti-Cal forms are currently not returned to the counties, the county automated model system will not be able to track the delivery of dental services. Also, because dentists often wait until all treatment is completed before submitting a claim, claims are often four to six months "old." As a result, local county programs will need to track dental screening manually by contacting providers and parents.

The Denti-Cal paid claims tape will be used at the State level to support the dental periodicity function. Dental periodicity notices will be issued one year from the date a dental screen has occurred. Medi-Cal eligible children who receive the following procedures will be counted as an EPSDT dental screen:

- 9010--Initial exam (one time only)
- 9049--Dental prophylaxis (without fluoride) for children aged 13 and under
- 9050--Dental prophylaxis (without fluoride) for children aged 14 to 20
- 9061--Fluoride (including prophylaxis) for children aged 4 and under
- 9062--Fluoride (including prophylaxis) for children aged 5 to 17

In the future, interfaces could be established between MEDS and the Denti-Cal system to support automated tracking of dental services at the State level.

5. STATE MEDI-CAL CLAIMS PROCESSING SYSTEM

A new Medi-Cal Claims Processing System is currently being implemented. This system offers the potential of supporting the tracking of the delivery of EPSDT treatment services in the required time frame and the documentation requirements on the date of treatment initiation for each condition. It could also support the Federal reporting requirements on the number of problems for which treatment was initiated and the number of clients for which treatment has been initiated for all conditions.

To meet these objectives, the following events need to occur:

- To support tracking of treatment against the penalty clock, interfaces with MEDS must be established and the date of eligibility determination entered into the MEDS system.
- Providers must submit Medi-Cal claim forms in a timely fashion; if they do not, the system will not be timely enough to support the 120-day timing requirement.
- EPSDT-related treatment should be noted by the provider on the new Medi-Cal billing form.
- A method should be established to relate the PM 160 problem/procedure codes to the Medi-Cal treatment codes.

The last requirement is especially important. In the absence of a method to match a screening problem code with a particular treatment code, tracking of the occurrence and date of treatment initiation will necessarily be an approximation. That is, treatment encounters reported on Medi-Cal claims submitted within a given time period from the date of screen will be assumed to be related to open screening conditions. This approach may be useful to develop an estimate for the Federal reporting requirement--number of problems for which treatment was initiated this quarter (Report 9B). However, this method is less

accurate in meeting the Federal documentation requirement for the date of treatment initiation for each referrable condition. The difficulty is greater when several problems are identified during the screen. The State's plans to produce a report listing all Medi-Cal claims for a child with open screening conditions within a fixed period from the date of screen is a good start on the problem but, in the long run, may not be adequate.

There are two basic alternatives for dealing with the above issue:

- Modifying the PM 160 problem/procedure codes to conform to the Medi-Cal treatment codes
- Developing a cross-referencing method to relate the PM 160 codes with the Medi-Cal codes

Both approaches may be difficult because of the basic difference in the purposes of the two forms. The PM 160 form reports suspected conditions according to an abnormality identified by a specific screening procedure; the Medi-Cal form reports treatment delivered according to ICDA codes, which link body system pathology with medical treatment given. CHDP staff have estimated that approximately 70 percent of all treatment resulting from a screen stems from one PM 160-defined condition--History and Physical Examination.

The above approaches should be carefully evaluated as the State proceeds with the detailed design of the case management system. Until the necessary MEDS-CHDP-Medi-Cal interfaces are developed, treatment follow-up will still have to be performed manually by the CHDP worker by contacting providers and clients. This follow-up activity is especially important because the date of treatment initiation must be documented for all clients, not just those who request support services.

In addition, even if the necessary interfaces of MEDS and the CHDP and Medi-Cal claims processing systems are established, the time delays associated with obtaining and processing Medi-Cal claim forms and transmitting the necessary follow-up reports to the counties may be too long to meet county tracking

needs. For tracking, the Medi-Cal system may be best used as a backup to the county manual tracking systems. Its primary use may be in meeting Federal documentation and reporting requirements. To meet the 120-day timing requirement, CHDP workers may still have to perform treatment follow-up by contacting providers and parents. The model system report, "Clients Without Treatment Initiation," is intended to aid this process by prioritizing the clients in greatest need of follow-up.

6. STATE-LEVEL EPSDT SYSTEM

As discussed earlier, the State plans to develop an automated EPSDT case management system for operation at the State level. The State plans to develop an automated periodicity system and will, thus, be the main vehicle for issuing periodicity notices. (The State plans to perform this function for children two years of age or over.)

Nearly all the other functions performed by the automated county model system could be handled by the State system, once MEDS and the Medi-Cal Claims Processing Systems are implemented and the necessary interfaces established. The same output reports and tracking form produced by the county model system could be produced by the State system, as long as the required county input data are submitted to the State.

The problems described earlier regarding timely processing of data and transmittal of the various reports to the counties may limit the usefulness of the State system in supporting the penalty timing regulations. Various approaches for alleviating this problem, such as processing the PM 160 before all the editing has been completed in order to identify the occurrence of a screen more quickly, should be explored.

The State system may be viewed as a backup to those counties that implement the model automated system or a comprehensive manual system. Conversely, the State system may serve as the primary case management vehicle for counties whose resources and size do not permit or justify automation.

The State system will be the primary vehicle for meeting the Federal reporting requirements and many of the documentation requirements.

VI. SYSTEM IMPLEMENTATION ISSUES AND REQUIREMENTS

VI. SYSTEM IMPLEMENTATION ISSUES AND REQUIREMENTS

This chapter describes some key issues and requirements to be resolved in the implementation of the model system and the State case management system.

1. MODIFICATION OF ELIGIBILITY INPUT FORMS

To meet the penalty documentation requirements, the county eligibility documents (CA 2 and MC 210) will need to be revised to record the offer, decision, and date of decision of dental and support services. If the documents are not modified, a supplement to them should be instituted.

2. INCLUSION OF DATE OF ELIGIBILITY DETERMINATION IN MEDS SYSTEM

This item is considered, for practical purposes, the service request date and is, therefore, needed for tracking delivery of screening and treatment services. MEDS specifications need to be modified to include this data item.

In addition, MEDS specifications must be examined to ensure that they include the offer and date of decision of dental and support services.

3. TIMELY SUBMISSION OF THE PM 160 FORM

This is needed to support timely tracking of screening services. The State should consider establishing a time limit for submission of CHDP claims. The State should also consider entering screening data on unpaid claims to support tracking of screening, periodicity notification, etc.

4. TRACKING DELIVERY OF TREATMENT SERVICES

Treatment initiation must be tracked for penalty documentation purposes for all clients, not just those who request support services. Until interfaces of

the CHDP Claims Processing System and Medi-Cal Claims Processing System are established, which will permit relating particular screening codes to treatment codes, counties must continue to track treatment initiation manually. Listing all treatment claims against open screening conditions can provide an approximation for the Federal reporting requirements but is not adequate for either the penalty timing or the penalty documentation requirements. Either a cross-referencing method must be developed or the PM 160 form will need to be revised to match the Medi-Cal treatment codes.

5. MEETING FEDERAL REPORTING REQUIREMENTS

The State has the capability, now or in the future, with the implementation of the State periodicity module and the MEDS system, to meet almost all the Federal reporting requirements. Item 2 in Section I of the Child Health Quarterly Statues Report (number of individuals who requested EPSDT services) depends on MEDS. Until MEDS is operational, this item will have to be obtained from the counties. Item 3 (number of individuals who were due for assessment or reassessment) depends on the State periodicity module. Until this is operational, the counties will need to provide this information.

The PM 160 can support nearly all the items under Section II of the Quarterly Report. However, Item 4 of Section II (number of children with treatment initiated for all problems) will require that the PM 160 and Medi-Cal claim codes be matched. The approximation method proposed by the State to support the requirements in Section III (number of problems for which treatment was initiated) will not support this requirement in Section II.

A more detailed discussion of State methods of meeting the Federal reporting requirements is presented in a separate document.

6. TRACKING DENTAL SERVICES

Because the Denti-Cal claim form is not returned to the counties, tracking will need to be performed by the counties manually by contacting the provider or parent. Unless the form is returned to the county, tracking in an automated

manner would be restricted to the State and would depend on implementation of the MEDS system and the development of the necessary interfaces of MEDS and the Denti-Cal system. For the State to ensure that dental screens have occurred, the Denti-Cal paid claims tape will need to be merged with the MEDS database.

7. OPERATION OF STATE CASE MANAGEMENT SYSTEM

For those counties that do not automate and rely mainly on the State system for case management support, procedures for State acquisition, processing, and transmission of data back to the counties in a timely manner must be resolved. If the tracking and other reports are not furnished to the counties in a timely fashion, the counties will still have to operate manual case management systems. The additional technical assistance effort planned by HCFA will address this issue.

APPENDIX

SYSTEM DATA ITEMS

SYSTEM DATA ITEMS

This appendix describes the data items that would be included in the model system. Exhibit A, at the end of this appendix, presents a matrix indicating the source, module, and applicable Federal regulation/reporting requirement of each data item.

A glossary of the key data items in the model is presented below:

Case Name--The name of the client's parent or responsible relative.

Client Birth Date--The date of birth of each CHDP client..

Client Number--The Medi-Cal number of the CHDP client.

Contact Attempts--Screening Assistance, Screen Follow-Up, Treatment Follow-Up--An indication of an attempt to contact the client at each point in the case management process. The worker enters the type of attempt made (Home Visit, Office Visit, Telephone Call, Letter), the date the attempt was made, and whether or not the contact with the client was completed.

Declines Services--An indication of the client's declination of medical and/or dental services, after the client had requested a service.

Dental Services Decision--Indicates whether or not the client desires to receive a dental screen.

Dental Services Date--Indicates the date on which the client makes a decision on the offer of a dental screen.

Disposition Date--Indicates the date on which a case was closed for reasons other than services completion. See "Final Disposition" below.

Eligibility Determination Date--The date on which eligibility for Aid to Families with Dependent Children (AFDC) and/or Medi-Cal was (re)determined. For penalty purposes, this date will constitute the date of request for services.

Eligible Client Name--The name(s) of the Medi-Cal eligible individuals in the family household who are between the ages of 0-21.

Final Disposition--Indicates the reasons for case closure when case is being closed for reasons other than service completion. Such reasons include the client's declination of further treatment, inability to make contact with client, client's moving, loss of Medi-Cal eligibility, or the client's declination of further program participation.

Informing Date--The date on which the client was initially informed about CHDP services.

Informing Type--An indication of whether the CHDP informing was performed for the first time (INITIAL) or at eligibility redetermination for nonparticipating families (ANNUAL). The Initial Informing must be face-to-face.

Medical Services Decision--Indicates whether or not the client desires to receive a medical screen.

Medical Services Date--Indicates the date on which the client makes a decision on the offer of a medical screen.

Medical Screen Provider Type--Indicates whether the scheduled CHDP screen appointment is with a Public Health Clinic, Individual Private Practitioner, Prepaid Health Plan, or other (Neighborhood Health Center, School System, etc.).

Referable Conditions/Problems--Indicates the problems identified during the screen. In each box labeled "Tx Code," the worker enters a three-digit code to indicate screen procedure: First two digits are problem suspected, third digit is screener's follow-up code.

Screen Appointment Status--Indicates whether the client kept or missed the scheduled screening appointment (medical and dental screens).

Screen Date--Indicates the date on which the CHDP screen occurred (medical and dental screens).

Screen Deferral Date--If client has requested deferral (postponement) of a CHDP screen to a more convenient time, the date of the requested deferral date is entered.

Screen Results--Indicates the outcome of the CHDP screen; specifically whether problems were identified and, if so, the status of treatment. The worker notes one of the following situations:

- No problems
- Problems identified, treatment initiated for all conditions
- Problems identified, no treatment initiated for any condition during screen visit
- Problems identified, treatment initiated for one or more conditions, other conditions remaining
- Problems identified, client declined treatment
- Problems identified, treatment contraindicated

Screen Type--Indicates the type of screening services received by the client, Initial (first time screened) or Periodic (re-screening according to the State's periodicity schedule).

Screening Appointments--Indicates the names and addresses of medical and dental providers for screening appointments arranged by the CHDP worker. Also indicates the date and time of the appointments.

Service Request Date--Indicates the date on which the client requested a CHDP screen. For newly eligible families, this will be the date eligibility is determined; for already eligible families, this is the date the family is initially informed about the program.

Special Conditions--Indicates a condition discovered during screen that is considered particularly serious or chronic and warrants special attention during treatment follow-up.

Support Services Decision--Indicates the client's response to the offer of support services.

Support Services Date--Indicates the date on which the client makes a decision on the offer of support services.

Support Services Type Requested (Screen And Treatment Follow-Up)--Indicates the type of support services requested by the client (scheduling or transportation).

Support Services Date Provided (Screen And Treatment Follow-Up)--Indicates the date on which support services were provided by the county.

Treatment Appointments--Indicates the names and addresses of medical providers for treatment appointments arranged by the CHDP worker. Also indicates the date and time of the appointments.

Tx Code--An indication of each condition/problem identified during CHDP screen (see above, "Referable Conditions/Problems").

Tx Start Date-Indicates dates on which treatment was initiated for each coded condition.

EXHIBIT A(1)

Health Care Financing Administration

DATA ITEM LIST

DATA ITEM	SOURCE	MODULE	APPLICABLE FEDERAL REGULATION/REPORTING REQUIREMENT
Case Name	CHDP Referral Form	Intake/Informing	441.90 (b)(1); (2)(i)
Case Medi-Cal Number	CHDP Referral Form	Intake/Informing	441.90 (b)(1); (2)(i)
Eligibility Determination Date	CHDP Referral Form	Intake/Informing	441.90 (b)(1); (2)(i)
Case Address	CHDP Referral Form	Intake/Informing	
Telephone	CHDP Referral Form	Intake/Informing	
CHDP Eligible Client Name	CHDP Referral Form	Intake/Informing	441.90 (b)(2)(ii), (iv)
Sex (by Eligible Client)	CHDP Referral Form	Intake/Informing	
Medi-Cal Number (by Eligible Client)	CHDP Referral Form	Intake/Informing	
Birth Date (by Eligible Client)	CHDP Referral Form	Intake/Informing	
Informing Type/Date (Initial/Annual)	CHDP Referral Form	Intake/Informing	441.90 (b)(2)(i)
Medical Services (Decision/Date)	CHDP Referral Form	Intake/Informing	441.90 (b)(1)(iii); (2)(ii)
Dental Services (Decision/Date)	CHDP Referral Form	Intake/Informing	441.90 (b)(1)(iii); (2)(ii)
Support Services (Decision/Date)	CHDP Referral Form	Intake/Informing	441.90 (b)(2)(iv), (v)
Eligibility Worker Name/ID No./Phone	CHDP Referral Form	Intake/Informing	
Services Requested/ Rejected(Medical, Dental, Support)	CHDP Client Tracking Form	Screening Assistance	441.90 (b)(1)(iii); (2)(ii), (iv), (v)
Service Request Date	CHDP Client Tracking Form	Screening Assistance	441.90 (b)(1)(iii)
Screen Type	CHDP Client Tracking Form	Screening Assistance	
Contact Attempts-- Screening Assistance	CHDP Client Tracking Form	Screening Assistance	441.71 (a)(2)(ii)(C); (a)(3)(ii)(C)
Declines Services (Medical/Dental)	CHDP Client Tracking Form	Screening Assistance	441.90 (b)(2)(ii)
Screen Deferral Date	CHDP Client Tracking Form	Screening Assistance	441.90 (b)(1)(iii)
Support Services (Type Requested/Date Provided)	CHDP Client Tracking Form	Screening Assistance	441.71 (a)(2)(ii)(C); (a)(3)(ii)(C); 441.90 (b)(2)(iv), (v)
Screening Appointments (Medical/Dental)	CHDP Client Tracking Form	Screening Assistance	441.71 (a)(i)(ii)(C); (a)(3)(ii)(C)
Worker Name/ID No./ Phone/Date	CHDP Client Tracking Form	Screening Assistance	
Contact Attempts-- Screen Follow-Up	CHDP Client Tracking Form	Screen Follow-up	441.71 (a)(2)(ii)(C); (a)(3)(ii)(C)

EXHIBIT A(2)

DATA ITEM	SOURCE	MODULE	APPLICABLE FEDERAL REGULATION/REPORTING REQUIREMENT
Screen Appointment Status/Date (Medical/Dental)	CHDP Client Tracking Form	Screen Follow-Up	441.71 (a)(2)(ii)(C); (a)(3)(ii)(C); 441.90 (b)(3)(ii), QCHSR II4
Screen Results	CHDP Client Tracking Form	Screen Follow-Up	441.90 (b)(3)(iii); (iv); QCHSR II2
Worker Name/ID No./ Phone/Date	CHDP Client Tracking Form	Screen Follow-Up	
Contact Attempts	CHDP Client Tracking Form	Treatment Follow-Up	441.71 (a)(2)(ii)(C); (a)(3)(ii)(C)
Referable Conditions (Code/Tx Start Date)	CHDP Client Tracking Form	Treatment Follow-Up	441.90 (b)(3)(iii); (iv); QCHSR II3, III1*
Support Services (Type Requested/ Date Provided)	CHDP Client Tracking Form	Treatment Follow-Up	441.71 (a)(2)(ii)(C); (a)(3)(ii)(C)
Treatment Appointments (Code/Provider/ App. Date & Time)	CHDP Client Tracking Form	Treatment Follow-Up	441.71 (a)(2)(ii)(C); (a)(3)(ii)(C)
Final Disposition	CHDP Client Tracking Form	Final Disposition	441.71 (a)(2)(ii)(A,B,C); 441.71 (a)(3)(ii)(A,B,C)
Disposition Date	CHDP Client Tracking Form	Final Disposition	441.71 (a)(2)(ii)(A,B,C); 441.71 (a)(3)(ii)(A,B,C)
CHDP Assessment	PM-160	Screen Follow-Up	441.90 (b)(3)(ii)
No Problems Suspected	PM-160	Screen Follow-Up	441.90 (b)(3)(iii); QCHSR II2
Treatment Refused, Contraindicated, Not Needed	PM-160	Treatment Follow-Up	441.71 (a)(2)(ii)(C)
Follow-Up Codes by Procedures	PM-160	Treatment Follow-Up	441.90 (b)(3)(iii); QCHSR II3, III1*
Problem Suspected-- New/Known	PM-160	Treatment Follow-Up	441.90 (b)(3)(iii); (iv); QCHSR II3, III1*
Date of Service	PM-160	Screen Follow-Up	441.90 (b)(3); QCHSR II 1
Type of Screen	PM-160	Screen Follow-Up	
Immunization Status	PM-160	Management Reporting	QCHSR II 5, 6; 441.90 (b)(3)

* Quarterly Child Health Status Report requirements can be met using the MMIS only if California revises PM-160 to match the Medi-Cal treatment codes, or develops a cross-referencing between PM-160 codes and Medi-Cal codes.